Agency Legislative Proposal - 2022 Session

Document Name: 100121_OHS_CommunityBenefits

(If submitting electronically, please label with date, agency, and title of proposal – 092621_SDE_TechRevisions)

State Agency: Office of Health Strategy

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Lead agency division requesting this proposal: Health Innovation

Agency Analyst/Drafter of Proposal: Kelly Sinko

Title of Proposal: An Act Concerning the Office of Health Strategy's Recommendations Regarding Various Revisions to Community Benefit Programs Administered By Hospitals

Statutory Reference: 19a-127k of the Connecticut General Statues

Proposal Summary:
The proposed changes will update the community benefits guidelines and reporting requirements outlined in §19a-127k in a manner that 1) promotes the Governor's commitment to addressing equity issues in health and healthcare and 2) shifts responsibility for community benefit data collection and analysis from the Office of Healthcare Advocate to the Office of Health Strategy (OHS). The proposal will remove the references to Managed Care Organizations from the statute and makes other changes to strengthen and improve the timing, content, regularity, and uniformity of annual updates. The proposal will require OHS to make the hospital submissions available to the public on the OHS website and will require OHS to annually develop a summary and analysis of such reports received.

PROPOSAL BACKGROUND

◊ Reason for Proposal

Please consider the following, if applicable:

(1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? No

(2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year? The trend to link community benefits with CHNAs is mirrored in at least 10 other states, and several New England states are leveraging community benefits to improve community health. This proposal shifts existing requirements from one agency to another to be more consistent with OHS' mission and focus on "promoting effective health planning and the provision of quality health care in the state," which incorporates the community benefit activities into many of its decisions.

(3) Have certain constituencies called for this action? No

(4) What would happen if this was not enacted in law this session?

Failure to enact the proposed changes maintains the current statutory scheme, leaving reporting required by this statute under the authority of the Office of Healthcare Advocate, or its designee. Hospitals would not be required to submit an annual report with updates on their community benefit activities, and further details on the Community Health Needs Assessments and Implementation Strategies will not be available.

◊ **Origin of Proposal** ☐ **New Proposal** ☒ **Resubmission**

If this is a resubmission, please share:

(1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?* Timing of negotiated draft presentation to legislators was late in session

(2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal? Yes

(3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation? Office of Health Strategy, Health Equity Solutions, and the Connecticut Hospital Association

(4) What was the last action taken during the past legislative session? JFS out of committee HB 6550

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PROPOSAL IMPACT

◊ **AGENCIES AFFECTED** (*please list for each affected agency*)

Agency Name: Office of Healthcare Advocate
Agency Contact (*name, title, phone*): Sean T. King, Staff Attorney 3, (860) 331-2463
Date Contacted: August 13, 2019 and September 24, 2019

Approve of Proposal ☒ **YES** ☐ **NO** ☐ **Talks Ongoing**

Summary of Affected Agency's Comments
OHA has not published any reports on hospital community benefit programs since 2010. OHA has communicated to OHS that they are not opposed to the transfer of this statute to OHS. On July 30, 2020, OHA and OHS executed an MOU whereby OHA designated OHS as its agent for the enforcement of the community benefit statute.

Will there need to be further negotiation? ☐ **YES** ☒ **NO**

◊ **FISCAL IMPACT** (*please include the proposal section that causes the fiscal impact and the anticipated impact*)

Municipal *(please include any municipal mandate that can be found within legislation)* N/A
State OHS can conduct this report within existing appropriations.
Federal N/A
Additional notes on fiscal impact N/A

◊ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

This proposal's shift of the required community benefit reporting from OHA to OHS promotes more consistent hospital reporting and data analysis, which is within OHS' statutory mandate. OHA's current guidance to hospitals regarding its enforcement of this statute directs hospitals to submit specified data to OHS, as OHA's designee, as satisfying the reporting requirement. OHS' mission and focus on "promoting effective health planning and the provision of quality health care in the state" leads to the incorporation of community benefits into many of its Certificate of Need (CON) decisions. Additionally, with OHS' work on community health the move of community benefits reporting will allow for aligning of initiatives. This proposal requires that reporting entities submit their Community Health Needs Assessments, Implementation Strategies, and annual reports to OHS. OHS will produce and make accessible online for the public a report annually based on the submitted information from the hospitals.

◊ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate? Is that data currently available or must it be developed? Please provide information on the measurement and evaluation plan. Where possible, those plans should include process and outcome components. Pew MacArthur Results First evidence definitions can help you to establish the evidence-base for your program and their Clearinghouse allows for easy access to information about the evidence base for a variety of programs.

Data from hospital reporting including the IRS Form 990, Community Health Needs Assessment, and corresponding Implementation Strategy will give a landscape of the community benefits work being completed in Connecticut. Additionally, this proposal requires an annual report with updates on the community benefit activities, as well as additional information regarding the CHNA and Implementation Strategies. These data aggregated with additional hospital data provided to OHS will facilitate greater detail and granularity of analysis of hospital engagement with their communities, how hospitals

prioritize and address community needs identified in their CHNA, and better inform OHS oversight of the impact of transactions within its oversight authority.

Insert fully drafted bill here

Section 1. Section 19a-127k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2023*):

(a) As used in this section:

[(1) "Community benefits program" means any voluntary program to promote preventive care and to improve the health status for working families and populations at risk in the communities within the geographic service areas of a managed care organization or a hospital in accordance with guidelines established pursuant to subsection (c) of this section;

(2) "Managed care organization" has the same meaning as provided in section 38a-478;

(3) "Hospital" has the same meaning as provided in section 19a-490;

(b) On or before January 1, 2005, and biennially thereafter, each managed care organization and each hospital shall submit to the Healthcare Advocate, or the Healthcare Advocate's designee, a report on whether the managed care organization or hospital has in place a community benefits program. If a managed care organization or hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (d) of this section.

(c) A managed care organization or hospital may develop community benefit guidelines intended to promote preventive care and to improve the health status for working families and populations at risk, whether or not those individuals are enrollees of the managed care plan or patients of the hospital. The guidelines shall focus on the following principles:

(1) Adoption and publication of a community benefits policy statement setting forth the organization's or hospital's commitment to a formal community benefits program;

(2) The responsibility for overseeing the development and implementation of the community benefits program, the resources to be allocated and the administrative mechanisms for the regular evaluation of the program;

(3) Seeking assistance and meaningful participation from the communities within the organization's or hospital's geographic service areas in developing and implementing the program and in defining the targeted populations and the specific health care needs it should address. In doing so, the governing body or management of the organization or hospital shall give priority to the public health needs outlined in the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7; and

(4) Developing its program based upon an assessment of the health care needs and resources of the targeted populations, particularly low and middle-income, medically underserved populations and barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care. The program shall consider the health care needs of a broad spectrum of age groups and health conditions.

(d) Each managed care organization and each hospital that chooses to participate in developing a community benefits program shall include in the biennial report required by subsection (b) of this section the status of the program, if any, that the organization or hospital established. If the managed care organization or hospital has chosen to participate in a community benefits program, the report shall include the following components: (1) The community benefits policy statement of the managed care organization or hospital; (2) the mechanism by which community participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were considered in developing and implementing the community benefits program; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) measures taken to evaluate the results of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; and (7) a summary of the extent to which the managed care organization or hospital has developed and met the guidelines listed in subsection (c) of this section. Each managed care organization and each hospital shall make a copy of the report available, upon request, to any member of the public.

(e) The Healthcare Advocate, or the Healthcare Advocate's designee, shall, within available appropriations, develop a summary and analysis of the community benefits program reports submitted by managed care organizations and hospitals under this section and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than October 1, 2005, and biennially thereafter, the Healthcare Advocate, or the Healthcare Advocate's designee, shall make such summary and analysis available to the public upon request.

(f) The Healthcare Advocate may, after notice and opportunity for a hearing, in accordance with chapter 54, impose a civil penalty on any managed care organization or hospital that fails to submit the report required pursuant to this section by the date specified in subsection (b) of this section. Such penalty shall be not more than fifty dollars a day for each day after the required submittal date that such report is not submitted.]

(1) "Community benefit partners" means federal, state, and municipal government and private sector entities such as faith-based organizations; businesses; the education sector and academia; healthcare organizations; health departments; philanthropy; entities specializing in housing, justice, planning and land use, public safety or transportation; and tribal organizations, which, in partnership with hospitals, play an essential role with respect to the policy, system, program, and financing solutions necessary to achieve community benefit program goals;

(2) "Community benefit program" means any voluntary program or activity to promote preventive health, to protect health and safety, to improve health equity and reduce health disparities, to improve the health status for all populations within the geographic service areas of a hospital whether or not those individuals are patients of the hospital, and to reduce the cost and economic burden of poor health;

(3) "Community benefit program reporting" means a community health needs assessment, implementation strategy, and an annual report, as more fully described in this section;

(4) "Community health needs assessment", means a written assessment, as described in 26 CFR 1.501(r)(3);

(5) "Health disparity" means a particular type of health difference that is closely linked with social or economic disadvantages that adversely affect groups of people who have systematically experienced greater social or economic obstacles to health or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion;

(6) "Health equity" means that everyone has a fair and just opportunity to be as healthy as possible, which encompasses removing obstacles to health such as poverty, racism, and their consequences, including a lack of equitable opportunities, access to good jobs with fair pay, quality education and housing, safe environments, and health care;

(7) “Hospital” means a nonprofit entity licensed as a hospital pursuant to chapter 368v that is required to annually file Internal Revenue Service form 990;

(8) "Implementation strategy" means a plan as described in 26 CFR 1.501(r)(3) that is adopted by an authorized body of the hospital and documents how the hospital intends to address identified community health needs; and

(9) "Meaningful participation" means that (1) residents of a hospital's community have an appropriate opportunity to participate in planning and decisions, (2) such participation includes but is not limited to residents who face the greatest health disparities; (3) the participation influences the hospital's planning; and (4) participants receive summary information about how input was or was not utilized.

(b) Beginning January 1, 2023 and consistent with the deadlines set forth in this section, subject to any filing extension granted by the Office of Health Strategy, each hospital shall submit community benefit program reporting to the Health Systems Planning Unit of the Office of Health Strategy, or to a designee selected by the executive director of the Office of Health Strategy.

(c) Each hospital shall submit its community health needs assessment to the Office of Health Strategy within thirty days of the assessment being made public. Submissions shall contain:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)(3)(b)(6)(i), and as included in its federal filing submitted to the Internal Revenue Service:

(A) A definition of the community served by the hospital and a description of how the community was determined;

(B) A description of the process and methods used to conduct the community health needs assessment;

(C) A description of how the hospital solicited and took into account input received from persons who represent the broad interests of the community it serves;

(D) A prioritized description of the significant health needs of the community identified through the community health needs assessment, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs;

(E) A description of the resources potentially available to address the significant health needs identified through the community health needs assessment; and

(F) An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding community health needs assessment, to address the significant health needs identified in the hospital's prior community health needs assessments.

(2) Additional documentation of the following:

(A) Names of individuals responsible for developing the needs assessment;

(B) Demographics of the population within the geographic service area, and to the extent feasible, detail with respect to health disparities, health risk, insurance status, service utilization patterns, and cost;

(C) Description of the health status and health disparities affecting the population within the geographic service area, particularly those experienced by a representative spectrum of age, racial and ethnic groups, incomes, and medically underserved populations;

(D) Description of meaningful participation of community benefit partners and diverse community members in assessing community health needs, priorities, and target populations;

(E) Description of barriers to achieving or maintaining health, and to accessing health care, such as social, economic, and environmental barriers; lack of access to or availability of sources of health care coverage and services; and lack of access to and availability of prevention and health promotion services and support;

(F) Recommendations with respect to the role that the state and other community benefit partners could play in removing the barriers described in subparagraph (E) and enabling effective solutions; and

(G) Any additional information, data, or disclosures that the hospital voluntarily chooses to include as may be relevant to its community benefit program.

(d) Each hospital shall submit its implementation strategy to the Office of Health Strategy within thirty days of the implementation strategy being made public. Submissions shall contain:

(1) Consistent with the requirements set forth in 26 CFR 1.501(r)(3), and as included in its federal filing submitted to the Internal Revenue Service:

(A) With respect to each significant health need identified through the community health needs assessment, either (i) describes how the hospital plans to address the health need; or (ii) identifies the health need as one the hospital does not intend to address and explains why the hospital does not intend to address the health need;

(B) For significant health needs described in subparagraph (A)(i) of this subdivision, describes the actions the hospital intends to take to address the health need and the anticipated impact of these actions; identifies the resources the hospital plans to commit to

address the health need; and describes any planned collaboration between the hospital and other facilities or organizations in addressing the health need; and

(C) For significant health needs identified in subparagraph (A)(ii) of this subdivision, describes why a hospital is not addressing a significant health need.

(2) Additional documentation of the following:

(A) Names of individuals responsible for developing the implementation strategy;

(B) Description of meaningful participation from community benefit partners and diverse community members including the process of soliciting public commentary on its implementation strategy, a compilation of all written public commentary submitted, and any revisions made in response to commentary prior to finalizing their strategy;

(C) Community health needs and health disparities that were prioritized in developing the implementation strategy with consideration given to the most recent version of the state health improvement plan prepared by the Department of Public Health pursuant to section 19a-7;

(D) Reference citing evidence, if available, that shows how these actions are intended to address the corresponding need or reduction in disparity;

(E) Planned methods for the ongoing evaluation of proposed actions and corresponding process and outcomes measures intended for use in assessing progress or impact;

(F) How the hospital solicited commentary on the implementation strategy from the communities within such hospital's geographic service area and revisions to the strategy based on such commentary; and

(G) Any other information that the hospital voluntarily chooses to include as may be relevant to its community benefit programs such as data; disclosures; expected or planned resource outlay, investments, or commitments including staff, financial, or in-kind.

(e) On or before October 1, 2023, and annually thereafter, each hospital shall submit to the Office of Health Strategy a status report on such hospital's community benefit program. The report shall include the following components:

(1) Major updates with respect to community health needs, priorities, and target populations, if any;

(2) Progress on components of the implementation of the actions established in the implementation strategy;

(3) Major changes to the proposed implementation strategy and associated actions; and

(4) Financial and other resources allocated or expended that supported the actions in the implementation strategy.

(f) Notwithstanding section 19a-755a, to the full extent permitted in 45 CFR 164.514(e) specific to limited data sets, the Office of Health Strategy shall make data in the All-Payer Claims Database available to hospitals for use in their community benefit programs and activities solely for the purposes of: (1) conducting the community health needs assessment activities set forth in subsection (c) of this section; (2) preparing and undertaking the implementation strategy as set forth in subsection (d) of this section; and (3) fulfilling the reporting obligations set forth in subsection (e) of this section. Any disclosure made pursuant to this subsection (f) of information other than health information shall be made in a manner to protect the confidentiality of such other information as required by state and federal law.

(g) A hospital shall not be responsible for limitations in its ability to fulfill community benefit reporting requirements set forth in subsections (c) through (e), inclusive, of this section if the data referenced in subsection (f) of this section are not made available to the hospital to support the activities necessary to achieve these requirements.

(h) On or before April 1, 2024, and annually thereafter, the Office of Health Strategy shall develop a summary and analysis of the community benefit reporting submitted during the previous calendar year and post such summary and analysis on its internet website and solicit stakeholder input through a public comment period. The Office of Health Strategy shall use such reporting to:

(1) identify additional stakeholders that may be engaged to address identified community health needs including but not limited to the following stakeholders: federal, state and municipal entities; non-hospital private sector healthcare providers; and private sector entities that are not healthcare providers, including community-based organizations, insurers, and charitable organizations;

(2) determine how each identified stakeholder could assist in addressing identified community health needs or augmenting solutions or approaches reported in the implementation strategies;

(3) determine whether to make recommendations to the Department of Public Health in the development of its state health assessment and state health improvement plan; and

(4) inform the statewide facilities and services plan under section 19a-634.

(i) Each for-profit entity licensed as an acute care general hospital shall be considered a hospital for the purposes of this section and shall submit community benefit program reporting

documentation as required by this section, including documentation consistent with the reporting schedule and reasonably similar to what would be included on hospitals' federal filings to the Internal Revenue Service, where applicable.